Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Service Date**	**:24-Jun-2025** **Network** : Green
Card No	: **I040-029-119600415-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **MOHAMMED SHAHAB UDDIN ABDUL MABUD**	**Doctor's Name**	**:DR Amaizah**
Payer Name	: **UNION INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**		
Validity	: **02-01-2025** To **01-01-2026**	**Remarks**	:
Gender	: **Male**		
Date Of Birth	: **08-Mar-1985**		
Patient's Tel No	: **0581676397**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pc : pain in both ears associated with serous secretions from both ears started 17/06/25 previously fubgal infection of skin o/e : serous fluid filled in ear canal white and yellow patches **Duration:**

Vitals: Temp : 36.2 Bp :126 Pulse :71 Resp :18

Clinical Findings:

Diagnosis: H66.017 - Ac suppr otitis media w spon rupt ear drum, recur, unsp ear,R50.9 - Fever, unspecified,R21 - Rash and other nonspecific skin eruption,B35.0 - Tinea barbae and tinea capitis, **Date of Onset** :24/52/2025

Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP **Estimated Cost** :

Prescriptions: 0397-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : DR Amaizah **Stamp :**

Dr. Amaizah Ishtiaq
General Practitioner
DHA: 98486553-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient 's signature{Parent : if minor} **Date :** 24-Jun-2025

Signature : **Date** : 24-Jun-2025